

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030615  
7534  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7534

FILED AUG 1 1963

|                     |              |  |
|---------------------|--------------|--|
| VS 300<br>Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS |
| 1                   |              |  |
| 2 2/10              |              |  |
| 3                   |              |  |
| 4 2                 |              |  |
| 5 9                 |              |  |
| 6                   |              |  |
| 7 1                 |              |  |
| 8 1                 |              |  |
| 9                   |              |  |
| 10                  |              |  |
| 11                  |              |  |
| 12 99.2             |              |  |
| 13                  |              |  |
| 91                  |              |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN St. Louis<br>c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION DOA Homer G. Phillips Hosp.  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri<br>b. COUNTY<br>c. CITY OR TOWN St. Louis<br>d. STREET ADDRESS (If outside, give location)<br>4274 E. Labadie Avenue |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>De Witt Wallace  |  | 4. DATE OF DEATH<br>Month Day Year<br>7 21 1963   |   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>Negro  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>  | 8. DATE OF BIRTH<br>3-8-1923  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Construction Worker  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   | 11. BIRTHPLACE (City and state or country)<br>Mississippi                     |
| 13a. FATHER'S NAME<br>Humphrey Wallace  |  | 13b. MOTHER'S MAIDEN NAME<br>Gertrude Porter  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of serv)<br>Yes WW 2  |  | 17. INFORMANT<br>Mary Wallace 4274 E. Labadie Avenue  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shock resulting from Hemorrhage resulting from stab wound, suffered when stabbed with knife in hands of one John Johnson in a location in vicinity of 800 South Kingshighway about 11:30 A.M.<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>Excusable Homicide   |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br>982x 2 in above   |   |
| 20c. TIME OF INJURY<br>11:30 a.m.<br>7-20-63  | 20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street 18   | 20f. CITY, TOWN, OR LOCATION<br>St. Louis, Mo                                 |
| 21. I attended the deceased from 1:30 A to and last saw her alive on<br>Death occurred at 1:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |
| 22a. SIGNATURE<br>(Degree or title)<br>Helen L. Taylor Coroner  |  | 22b. ADDRESS<br>1300 Clark Ave.   | 22c. DATE SIGNED<br>7-22-63   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  | 23b. DATE<br>7-26-63   | 23c. NAME OF CEMETERY OR CREMATORY<br>National  | 23d. LOCATION (City, town, or county) (State)<br>Jefferson Barracks, Missouri |
| 24. FUNERAL DIRECTOR<br>Ellis Funeral Home, Inc. 2820 Stoddard St.  |  | 25. DATE RECD. BY LOCAL REG.<br>JUL 22 1963   | 26. REGISTRAR'S SIGNATURE<br>Earl Smith. M.D.                                 |

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4198

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.